Pink Ribbon Gala Grant Application

If you are a Mississippi resident diagnosed with Cancer, and would like to receive assistance, please complete this form and return it to:

The Pink Ribbon Gala Fund
Post Office Box 11188
Jackson, MS 39213

Funding will be given directly to the provider for product or services on behalf of the applicant. **Submitting this application does not guarantee funding approval.**

Funds for this application are provided by
The Pink Ribbon Gala

Please print clearly and complete BOTH SIDES of this form.

NAME:_____

ADDRESS:_____

CITY:_____ STATE: _____ ZIP CODE:_____

PHONE:_____ DATE OF BIRTH:_____

SECOND PHONE NUMBER, IF POSSIBLE:_____

DATE DIAGNOSED WITH CANCER:_____

TOTAL HOUSEHOLD MONTHLY INCOME:_____

INSURANCE:_____ MEDICAID and/or MEDICARE? _____

TYPE OF ASSISTANCE REQUESTED
Please check ALL that apply.

_____Financial Assistance to Help Cover:
- _____Medical Bills (Directly Related to Cancer Diagnosis)
- _____Cancer Screening
- _____Cancer Diagnosis
- _____Transportation to medical visits or treatments
- _____Utility bill unable to pay due to hardship from cancer expenses

_____Prosthesis
_____Wig, Hats, Scarves (Head covering)
_____Other (Please Specify)_____

Please give details about the help you are seeking, so we may have a complete picture of your situation. You may attach an additional sheet, if necessary. Also, please attach supporting documentation of the need, i.e., medical bills, utility bills, etc.

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DOCTOR VERIFICATION STATEMENT:
I verify that the person identified in this application has cancer.
Doctor's Name:_____ (Please Print)

Have Your Doctor Sign Here:_____ Date:_____

APPLICATION VERIFICATION STATEMENT:
I swear that the information on this form is true and accurate.

Applicant Signature_____ Date:_____

How did you receive this application?_____

May we contact you for a statement which may be used in our promotion materials?_____
(We will NOT use your name, only your information)